Boulder

Telehealth Solutions for Addiction Treatment

AN IMPLEMENTATION ROADMAP FOR HEALTH PLANS

Contents

Executive Summary

Telemedicine-based care for addiction treatment has the potential to solve critical gaps in care access, quality, and equity: enabling specialized services to be delivered at the speed and scale necessary to address America's substance use disorder (SUD) crisis.

FDA-approved medications, like buprenorphine for **opioid use disorder (OUD)**, are particularly effective clinical treatments.[1, 2] Despite their remarkable benefits for patient health, safety, and quality of life, **medications for addiction treatment (MAT)** are underutilized nationwide.[3]

For nearly twenty years, national strategies to improve the availability of addiction treatment have had only modest results.[4] A shortage of prescribing clinicians — limited by regulatory policies, payment mechanisms, and professional culture — fails to meet the need for treatment, as over 20 million Americans experience SUD.[5]

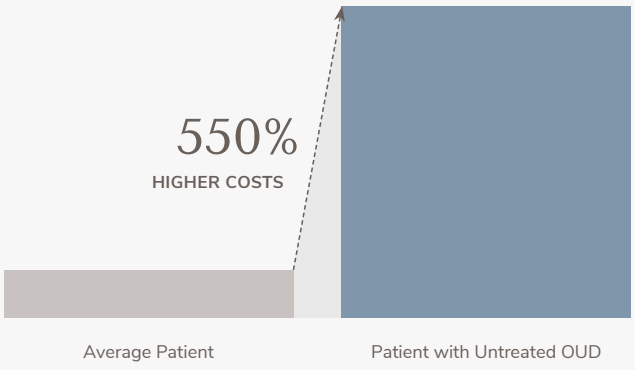
The consequences are tragic: between 1999 and 2018, 450,000 people died from an opioid overdose;[6] 95,000 Americans die from alcohol use every year;[7] and deaths from stimulants like methamphetamine and cocaine are accelerating.[8] Overdose fatalities have grown *exponentially* for the last 40 years.[9]

COVID-19 has further limited treatment access, exacerbated existing SUDs, and induced psychosocial stressors (unemployment, isolation) linked to new use disorders, mental health issues and suicides. More than 80,000 Americans died from an overdose between June 2019 and May 2020,[10] the highest annual rate ever recorded, climbing 30%+ year-over-year in many states.[11]

These challenges invoked the rapid deployment of telehealth. A growing cohort of innovative, technology-enabled providers are delivering addiction treatment services in response and — in partnership with insurers — offer a promising shared opportunity to meet urgent need.

Health insurers are key stakeholders in the national effort to expand care with MAT. Payers also stand to realize economic benefit, as they currently bear substantial costs for the opioid crisis: untreated OUD costs private plans 550% more per member — >$16,000 PPPY[12] — and >80% of people who need care do not receive it.[13]

Incremental Cost of Untreated Opioid Use to Private Health Plans



Insured members who *do* access treatment often utilize out-of-network providers with varying quality, defaulting to the most expensive "level of care" in inpatient facilities, even though such care may at times be inferior and even associated with increased overdose.[14]

In a study conducted by Optum,[15] out-of-network residential treatment costs employers and employees an estimated $44,000 per 90-day episode, compared to $13,000 for the same treatment delivered by in-network providers.* And destination facilities' 30-day and 90-day readmission rates are 100 percent higher, compared with in-network facility discharges.**

Telehealth providers promise to engage members earlier, respond to individual needs, help navigate to the most appropriate evidence-based services, prove ROI with sophisticated reporting and analytics infrastructure, and recoup billions of dollars lost due to current lack of treatment or provision of ineffective treatment.

THIS PAPER DISCUSSES:

- The benefits of incorporating high-quality digital solutions into your network strategy for SUD treatment
- How insurers can take advantage of this emerging opportunity to meet critical needs for their members and clients
- Criteria payers should consider when evaluating telehealth partners for MAT

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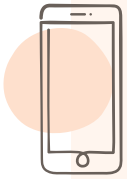
* Comparison of average 90-day episode-of-care cost for out-of-network residential treatment ($43,570) to that for in network residential treatment ($13, 289). "Episode of Care" is defined as claims between three days prior to admission through 90 days after discharge. Bolstrom, Affordability. May 2018.

** Optum comparative analysis of average annual 30- and 90-day readmission rates for in-network and out-of-network residential SUD treatment programs authorized for members from January 2016 to December 2017. Data includes membership in all age cohorts from the commercial book of business. Bolstrom. May 2018.



The Benefits of Telehealth SUD Treatment

Digital platforms for specific conditions and/or populations continue to develop as a vital part of US healthcare innovation — particularly during the COVID-19 response.

Solutions addressing OUD, for example, gained noteable traction in 2020, as regulatory tailwinds and increased investment bolstered an emerging cohort of digital-first providers.[16]

Several factors make telehealth a compelling modality for addiction treatment:

- **Large and growing supply & demand gap, perpetuated by structural constraints to MAT access.** As many as 6 million Americans have OUD.[17] Yet there are severe, chronic provider shortages: <5% of medical providers are licensed to prescribe buprenorphine,[18] and 40% who are licensed do not treat any patients.[19]
- **Inherent challenges of brick-and-mortar.** Political and community resistance (NIMBY) blocks outpatient facilities from opening in safe, convenient locations. Patients must frequently commute long distances to weekly prescriber visits, counseling, toxicology testing, and pharmacies.[20]

APRIL 2020

npr

Coronavirus Crisis Spurs Access To Online Treatment For Opioid Addiction

AUGUST 2020

The New York Times

Using Telemedicine to Treat Opioid Addiction

SEPTEMBER 2020

protocol

Pandemic waivers made it easier to get treatment for opioid addiction. That could all go away next month.

"People face the impossible choice between missing an appointment with a parole officer and going to jail, missing a clinical visit and losing medication they need to avoid full-blown withdrawal, or leaving kids with a babysitter they don't trust. The current system creates an impossible, no-win situation that works against its goals. Telemedicine removes these barriers."

— ALYSON SMITH, MD, MEDICAL DIRECTOR, BOULDER CARE. BOARD CERTIFIED IN ADDICTION MEDICINE.

- **Addiction as a chronic condition.** Acute (30–90 day) models are the norm, but decades of science show sustained treatment (12–36+ months) predicts long-term success.[21]
- **Rural populations are disproportionately affected by the opioid crisis.** Over half of rural counties do not have a single buprenorphine provider[22] and it is not feasible to build specialized facilities in many areas that need care most.
- **Impact of environmental and social context.** Care plans must consider behavioral health, education, and psychosocial needs given their profound influence on addictive disease and outcomes. Barriers exist related to transportation (e.g. revoked driver's license), financial hardship, legal, housing and child custody issues, or tenuous relationships with loved ones or employers. Treatment program rigidity frequently gets in the way of the most important functional goals of recovery.[23]
- **Patient experience in low-quality care.** Many options are fragmented, unaffordable, cookie-cutter, and lack evidence of success. Further, unplanned discontinuation of medication treatment can have catastrophic consequences for patients.[24]

It is difficult to imagine solving these intractable problems without technology that:

- scales quickly and affordably
- immediately expands access to overcome geographic and perceptual barriers
- increases supply of medical providers by making services delivery easier
- helps people sustain care over the dynamic course of addictive disease.

> "After a 2-hour bus ride, a security guard takes my phone. My kids aren't allowed in the waiting room. People are selling drugs in the parking lot. After years of trauma and abuse by a partner, to have a male stranger watch me give a urine sample. Treated like a criminal, not a mother, patient, and person worthy of dignity."
>
> **— MAT PATIENT IN TRADITIONAL OUTPATIENT. FOCUS GROUP INTERVIEW, CONDUCTED 2017 IN NEW HAMPSHIRE.**

Key Considerations for Insurers in Selecting a Telehealth SUD Partner

Legal and Regulatory Compliance Strategy

Telemedicine-based MAT providers face a particularly complex framework of federal and state-level policies. Some states prohibit the prescribing of buprenorphine remotely; others allow it with certain restrictions. Any potential partner offering treatment in multiple states must have a firm grasp of the requirements in every market in which they practice, or risk civil and criminal sanctions for operating an unlicensed, uncertified or non-compliant program. Multi-state providers should articulate viable growth plans that scale in a rapidly evolving regulatory environment.

REGULATORY FRAMEWORK

Providers must comply with federal registration and licensure requirements to prescribe buprenorphine for MAT (beyond those applicable to controlled substances), including a **Substance Abuse and Mental Health Services Administration (SAMHSA)** waiver and **Drug Enforcement Administration (DEA)** registration(s).

Each state then layers on different requirements based upon how SUD programs are defined and which regulators are involved. Beyond the state's Department of Health, this may include an opioid treatment authority, mental health agency, or office that licenses SUD programs specifically. Adding to the complexity, most laws never contemplated virtual models and contain provisions that are antiquated or impractical.[25]

Finally, lawmakers issued temporary actions to relax statutory and regulatory restrictions as part of the pandemic response, set to expire at the end of the COVID-19 public health emergency.

Key issues for due diligence include:

Patient Capacity Limits: To prescribe buprenorphine, practitioners must obtain a federal Drug Addiction Treatment Act of 2000 (DATA) waiver[26] and can treat a maximum of 30, 100, or 275 active patients depending on their qualifications and length of practice. This and other prescribing restrictions are contested by advocates and addiction specialists.[27]

In-Person Visit Requirements: The federal *Ryan Haight Act* [Ryan Haight Act, 21 USC § 829 (2008)] requires one in-person patient evaluation prior to subsequently receiving buprenorphine via telehealth. The DEA waived enforcement in 2020 due to the pandemic, and the policy's status post-emergency is a subject of ongoing review.[28]

In addition, telemedicine providers must operate in accordance with state laws and professional licensing board requirements that may impose in-person evaluation requirements independent of the federal mandate. *Illustrative examples:*

- Florida's emergency order was more restrictive than the DEA's waiver, permitting practitioners to prescribe via telemedicine only for existing patients for the purpose of treating chronic pain.[29]
- While Alaska's law requiring an in-person exam was waived for the health emergency, that waiver is dependent on the AK emergency declaration and subject to ongoing state-level renewal.[30]

- Other states with codified physical exam requirements (e.g., Minnesota,[31] Louisiana,[32] and Ohio[33]) or professional board practice requirements will similarly require ongoing state-based regulation and/or policy waivers.

SUD Program Licensure: Specialized state agencies and licensing boards regulate program types differently (e.g. residential versus private practitioners) and may impose additional requirements for buprenorphine.

Illinois's Division of Substance Use Prevention and Recovery, for example, currently requires an SUD program license for *any* addiction treatment services — including addiction-related counseling — and this license must be associated with an in-state brick-and mortar facility.[34]

"Despite many temporary rule waivers for telehealth, SUD treatment services remains a highly regulated specialty area.

Emerging companies seeking to enter this space face an extremely complicated regulatory framework — particularly on the state level — that can leave them feeling discouraged or, worse, tempted to take unadvisable shortcuts that put the company and its patients at risk.

In our discussions with state regulators, we are pleased to share that many states are actively discussing how they can incorporate telehealth into their SUD programs regulatory architecture. And, despite the complexities, there are bona fide, legally-compliant solutions to offer multistate SUD treatment services via telehealth."

— NATHANIEL M. LACKTMAN, CHAIR, TELEMEDICINE & DIGITAL HEALTH INDUSTRY TEAM, FOLEY & LARDNER LLP

GEOGRAPHIC COVERAGE AREAS AND EXPANSION TRAJECTORIES: TRADEOFFS TO CONSIDER

Health plans with national membership and/or who provide ASO services to self-insured companies generally look for telemedicine vendors with operations in all fifty US states. While a national footprint may ultimately be desirable, the MAT telehealth category is unique as a young sector with a dynamic regulatory landscape.

Policies differ in nearly every market and are changing in piecemeal, unpredictable fashion. Currently, to deliver entirely virtual MAT in all 50 states is prohibited by controlled substance prescribing regulations.

A vendor that promotes national capabilities or an aggressive expansion plan should prepare detailed implementation models which include how medical prescribers are licensed and staffed, any in-person components to the care delivery or patient recruitment model, and well-articulated contingency plans for potential regulatory scenarios.

Multi-state operations demand a sophisticated and nuanced approach to clinical operations. But partnering with specialized companies that fully appreciate and account for this responsibility can bring meaningful value to enterprise partners as the treatment landscape evolves.

RECOMMENDED STRATEGIES TO MITIGATE RISK:

- *Implement with a partner in a subset of target states as part of a thoughtfully sequenced national rollout over time.* Task telehealth partners with presenting a 12-18 month plan, including a clear strategy for member communications and support to ensure transparency about what services are available based on the location in which a member resides.

- *Add multiple telehealth providers to your network with complementary geographies.* Vendors should demonstrate deep expertise about the local healthcare delivery networks and regulatory requirements in their region.
- *Leverage telehealth partners for support and expertise in defining your shared implementation priorities.* This may include conducting claims analyses to identify members with diagnosed or likely SUD, targeting areas with MAT access gaps, or setting population health goals for addiction services utilization.

DIGITAL-FIRST SOLUTIONS OR INCUMBENT PROVIDER GROUPS?

Brick-and-mortar addiction treatment providers rarely offered telemedicine options until adoption became necessary during COVID-19.[35] Many HIPAA restrictions have been temporarily relaxed, allowing patient care via platforms like Zoom and FaceTime. Still, converting multi-site, in-person services models into virtual care is an immense undertaking, and operations do not easily translate.

There may be advantages to partnering with entities that built "digital-first" from the ground up, designing optimal processes for digital addiction care, rather than implementing wholesale changes to insurance contracting arrangements, implementation plans, staffing models, organizational culture, clinical operations workflows, and end-to-end patient experience.

There are additional benefits to partnering with technology-enabled providers, including their ability to be agile and capture new opportunities in a rapidly changing landscape, and to customize products to meet needs for partners and consumers.

However, digital-first market entrants must be held accountable for demonstrating robust internal legal and compliance capabilities.

For a multi-state provider, this will require substantial (multi-million dollar) investment that increases proportionately with the number of states in which they deliver services. Insurers are rightfully cautious about reputational and execution risk when working with early-stage companies.

RECOMMENDED STRATEGIES TO MITIGATE RISK:

- *Seek partners with strong clinical operations personnel, a track record of successful work with health insurers and large-scale implementations, and sufficient capital to ensure success without cutting corners.*
- *Engage a telehealth partner who takes the long-view on adopting compliant business practices and is active themselves in thought leadership to influence national dialogue about telemedicine policy.*
- *Regulations underlie many of the existing MAT access barriers that have perpetuated this crisis through unintended effects.* As public policies catch up with advances in technology and consumer demand, the most successful innovators will embrace the spirit of these policies for their intended aim: it is paramount that providers stay vigilant about each regulation intended to protect patient safety.

As policymakers call for more data to support telemedicine for SUD treatment, innovators play an important role. "Given the severity of the opioid epidemic, the low-rates of tele-SUD use that we observe represent a missed opportunity. As availability of tele-SUD is expanded, it will be important to monitor closely which tele-SUD delivery models are being deployed and their impact on access and outcomes" (JAMA, 2020).[36]

QUESTIONS FOR POTENTIAL TELEHEALTH PARTNERS

Clinical Operations

- ☐ How is your program staffed?
- ☐ In which states are your DATA-2000 practitioners licensed to practice medicine?
- ☐ In which states are your prescribing clinicians registered with the DEA to prescribe controlled substances?
- ☐ How will your model be implemented to comply with the regulatory environments of our key geographic coverage areas?
- ☐ What steps do you take to ensure X-DEA waiver compliance and staffing for waiver capacity?
- ☐ How does your operational model address federal and local requirements regarding physical examinations?
- ☐ What accreditations do you hold or have pending applications to obtain?

Multi-Market Growth

- ☐ What are your multi-state growth plans and projected timeline?
- ☐ Are you contracted with other public or private health plans? In which states?
- ☐ What experience do you have executing large-scale payer implementations? Who are your referenceable customers?
- ☐ What is your plan to address future policy changes without disruption to care?
- ☐ Who do you regularly consult, internally and externally, for legal, regulatory, and healthcare policy advisory?
- ☐ What data can you provide about your company's capital base and source(s) of financing to execute on your operational plans in a compliant manner?

Clinical Quality and Program Efficacy

Addiction treatment has long been mired in myth and misinformation: characterized by a lack of evidence-based care, antiquated (or outright predatory) practices, fraud, waste, and abuse.[37] New entrants are not necessarily better than the status quo, and buprenorphine provision has at times been part of unscrupulous practice.[38] People deserve low-barrier access to life-saving medication, but also a supportive, truly beneficial therapeutic relationship with their prescribing clinician and care team.

These elements of quality — and the patient healing they lead to — can be measured. One strength of digital health solutions is that they allow for better data tracking and reporting: creating an opportunity industry-wide for greater transparency, standardization, and comparable outcomes metrics as quality benchmarks.

FRAMEWORK FOR EVALUATION

Telehealth MAT providers are tasked with proving: a) telehealth care is as good as traditional brick-and-mortar outpatient treatment (non-inferiority), and b) known barriers to MAT are demonstrably reduced

> "Solutions like Boulder are helping to move health quality measurement from analog to digital measures consistent with CMS, NQF, and NCQA priorities. Digital-first measurement will create more accountability on the providers to deliver real outcomes, and enable faster iterations of quality improvement."
>
> **— ANDREY OSTROVSKY, MD, FORMER CMO OF U.S. MEDICAID**

to improve access, retention and medication adherence. Though there are limited trials examining the long-term impact of medication treatment for SUD patients at home,[39] those studies are reassuring.[40]

INDICATORS OF PROGRAM QUALITY

It can be challenging to assess quality in the addiction treatment industry. Some of the most well-reputed, established providers have entrenched policies characterized by bias and dogma, which directly contradict the medical literature and updated guidance.[41]

Clinical experts at your health plan should be involved early and often in the telehealth vendor selection process in interactive dialogue about clinical practices and treatment philosophy.

The nonprofit organization Shatterproof has developed National Principles of Care© for addiction treatment which offer a useful framework, as shown below.[42]

CLINICAL APPROACH

Personalized care plans that are continually reassessed. Intensifying clinical support has traditionally meant more demands on the patient: increasing frequency of clinical encounters like visits, drug screening or counseling.

> "Stigma is a pervasive barrier to addiction care that impacts every aspect of an individual's experience through the treatment system. The data are clear: many providers do not provide evidence-based care, and many more have stigmatizing and discriminatory beliefs about the disease of addiction. The development of tele-medicine solutions that adhere to these national principles is a real opportunity to change the industry."
>
> **— MATTHEW STEFANKO (HE/HIM), DIRECTOR, NATIONAL STIGMA INITIATIVE, SHATTERPROOF**

Telemedicine-enabled care can be both low-barrier *and* high-touch. As an individual's treatment plan evolves, new evidence-based strategies can be incorporated without the added time and resource burden of in-person encounters.

Tools for screening and monitoring. Tech-enabled providers can obtain clinical insights through meaningful, longitudinal data collection and aggregation. When evaluating a telehealth

SHATTERPROOF'S NATIONAL PRINCIPLES OF CARE©

1. Routine screenings in every medical setting
2. A personal plan for every patient
3. Fast access to treatment
4. Long-term disease management
5. Coordinated care for every illness
6. Behavioral health care from legitimate providers
7. Medication for addiction treatment
8. Recovery support services beyond medical care

SUD program, it is useful to understand which data are being collected and importantly, *how* they are applied to inform treatment.

PDMP (Prescription Drug Monitoring Programs): State-by-state databases help identify when a patient may be obtaining controlled substance prescriptions from multiple providers and pharmacies. This information must be used wisely, as precipitous changes in clinical management can be harmful.

Example 1: Co-prescription of buprenorphine and benzodiazepine.

- Unsure about how to treat patients who are co-prescribed buprenorphine with a benzodiazepine, some providers will automatically discontinue medication based on PDMP results, contra to guidance from the FDA[43] and others.
- Instead of sudden changes in care, data should be communicated with the patient and the other prescriber, helping the care team to better understand the circumstances and develop a collaborative plan.

Example 2: Discovering multiple opioid prescriptions and denying a buprenorphine prescription without intervention.

- A person with OUD may seek to obtain opioids in the safest and most predictable way possible. Finding multiple opioid prescribers in the PDMP could be an indication of a patient's use disorder, not a reason to deny buprenorphine treatment.[44]

Key takeaway: technology-enabled providers create a valuable opportunity to link two important things: 1) collection of real-time data that is actionable at point of care, and 2) clinical decision support that involves the patient and care team in an appropriate response before a negative outcome occurs.

Confirmation of buprenorphine adherence: Observed medication dosing and remote toxicology testing (urine/saliva) can be deployed via telemedicine as part of a comprehensive treatment plan.

Unlike urine toxicology screenings, saliva tests can be directly observed via telemedicine while enabling a private, respectful, and convenient patient experience.

The degree to which at-home testing and monitoring services are reimbursed by insurance is likely to play a role in the degree to which providers support their ongoing use post-pandemic.[45] The frequency of testing and role toxicology testing plays in routine care is being reexamined in light of the pandemic and expert consensus that there is scarce evidence that testing improves clinical outcomes.[46]

Key takeaway: whether services are provided via in-person programs or telehealth, it is useful to continually reevaluate best practices and add new tools to the toolkit. Encourage providers to incorporate interventions proven to change treatment strategies and drive meaningful outcomes.

Other key clinical principles:[47]

- *Low-Threshold Care*. Chronic diseases require an approach that is longitudinal and proactive. Providers should emphasize ease of initial contact, prompt assessment and home-based start to medication treatment, minimal program exclusion criteria (e.g., polysubstance use, co-occurring conditions), counseling targeted to those who want to take part, and no one-size-fits-all requirements.
- *Harm Reduction*. Providers should be aware of each patient's personal goals and work to help keep them safe, preventing comorbidity and death related to opioid exposure. The member's highest risk of death is when they do not receive treatment, and abrupt removal from prescribed medications places patients at grave risk of relapse and overdose.

- *Trauma-Informed Care.* Providers should reflect on how a history of trauma can color a participant's reactions, decisions, and engagement. Patients may have had negative healthcare experiences in the past, and attention to individual choice and autonomy is crucial.

"Addiction care has been practiced in ways unlike any other area of healthcare. Now that treatment is becoming more evidence- and person-based, telehealth offers patients a better toolset to help their recovery."

— STEPHEN MARTIN, MD, EDM, ASSOCIATE PROFESSOR, UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL AND MEDICAL DIRECTOR, BOULDER CARE. BOARD CERTIFIED IN ADDICTION MEDICINE.

For additional reading, see Dr. Stephen Martin's article in *Annals of Internal Medicine*: "The Next Stage of Buprenorphine Care for Opioid Use Disorder."

METRICS THAT MATTER

Acknowledging the addiction treatment field has suffered from a lack of evidence-based practices, there is an opportunity to define scientifically rigorous, progressive metrics to gauge program efficacy: not simply because they are data points that can be easily measured, but rather, because they map to a shared definition of success.[48]

Historically, for example, the proportion of urine toxicology tests positive for a given substance was a marker of treatment success. The recognition that OUD is a chronic health condition where return to use is expected calls into question the validity of this metric. Instead, the National Academy of Medicine recommends a set of person-centered measurements that include functional outcomes.[49]

QUESTIONS FOR POTENTIAL TELEHEALTH PARTNERS

Holistic, Coordinated Care

- ☐ What types of roles compose your care teams (clinical and non-clinical patient services)?
- ☐ How do you support services delivery across the continuum of care: i.e., coordination with primary care and other medical providers, mental health practitioners, other specialists, inpatient facilities, etc.?
- ☐ What resources do you make available to patients facing non-clinical issues related to their SUD?
- ☐ Do you work directly with community-based organizations, criminal justice, social support groups, or other ancillary services providers?
- ☐ Are patients regularly referred to you by other providers?
- ☐ How do you share information or collaborate on care plans with external providers and/or other individuals a patient has deemed important to their recovery?
- ☐ How do you support patients with polysubstance use (opioids, alcohol, methamphetamine, kratom, etc.)[50] and remain current on the substances most prevalent in the populations/ communities you serve?
- ☐ How do you support patients with co-occurring mental health conditions (e.g. depression, PTSD, anxiety, bipolar disorder) given their significant prevalence in this population?
- ☐ How do patients typically pay for your services? Are you contracted with other insurance providers? What resources do you offer patients to understand treatment options and affordability?

QUESTIONS FOR POTENTIAL TELEHEALTH PARTNERS

Program Guidelines

- ☐ Provide documentation on your philosophical approach to SUD treatment, services provided, and clinical practice guidelines. What team members assists in creating, reviewing, and continually evaluating these protocols?
- ☐ How are care decisions made and what is considered? (e.g., patient goals & preferences, industry guidelines, medical literature, systematic data collection and internal analyses, independent clinical decision-making?)
- ☐ Are your providers full-time employees or contracted? How regularly do they collaborate with each other and engage in continuous company-wide training & education, Quality Assurance efforts (supervision, chart reviews, etc.)?
- ☐ What communication channels are available to patients who need time-sensitive support or after-hours care? Can members contact their care team readily and easily?
- ☐ Have you engaged in any research studies, independent publications or peer-reviewed articles?

Principles of Care

- ☐ How do you make use of your platform to foster relationships with participants?
- ☐ What is your approach to monitoring and adjusting treatment plans to adapt to a member's level of engagement, acuity, or adherence?
- ☐ Does your program emphasize abstinence-only principles or abstinence as the primary end point?
- ☐ Does your program mandate counseling and/or mutual support groups (e.g. AA, NA) for all patients or instead follow SAMHSA guidance in facilitating it only for interested patients?
- ☐ Describe your DATA 2000 required process for referring interested patients to counseling.
- ☐ Do you have protocols for tapering off of buprenorphine and under what circumstances would you do this? How would you counsel a member interested in discontinuing buprenorphine?
- ☐ Are you registered with the prescription drug monitoring program (PDMP) in all states in which you operate? What is your protocol for checking PDMP and how do you support a member identified as getting medication from multiple pharmacies?
- ☐ What steps do you take to ensure there are no unexpected disruptions in medication prescriptions for any reason? (missed visits, insurance/pharmacy issues, patient financial hardship, office closures, etc.)

Outcomes and Quality Measures

- ☐ What is the average time from initial visit to a participant receiving their first prescription?[51]
- ☐ What is your 12-month retention rate and how do you work with members to determine length of treatment?[52]
- ☐ What is your policy to monitor buprenorphine adherence in a way that is non-punitive? What data can you show regarding medication adherence?
- ☐ How do you track patient progress in the context of their functional and clinical health outcomes and stated goals for recovery?

Technology Platform, Privacy, and Security

All telehealth solutions — and especially those applied to SUD treatment — require a multi-layered and interdependent approach to care delivery technology and the underlying practice management and medical records systems.

With so many new entrants into telehealth SUD treatment over the past year, and common language typically used to describe different treatment platforms and models, both insurers and consumers may find it difficult to assess providers based solely on the information published on a website or other marketing materials. These are important decisions, both in the context of patient experience and outcomes, but also in light of the regulations and legal obligations SUD providers face.

KEY TECHNOLOGICAL CONSIDERATIONS

Telehealth providers' technology platforms range from purpose-built, enterprise solutions to systems aggregated from various third party vendors. There are significant trade-offs associated with the latter approach: while it allows a new entrant to rapidly acquire and stitch together separate components into a delivery system, the integration of unrelated technologies — many of which were developed for a purpose entirely unrelated to patient care, and almost certainly not intended for SUD treatment — increases the risk of technological flaws that impact patient and provider experience, as well as health information privacy and security, while limiting flexibility to improve upon the existing solution.

Companies that invest in an internally developed, proprietary telemedicine platform offer the opportunity to provide a clinician/patient interface experience seamlessly integrated with electronic messaging, scheduling and appointment management, electronic health records, as well as clinical staffing and practice management.

These providers can also update their software, creating new features and improving clinician and patient experience, information security and data analytics capabilities in real time — all of which could ultimately be used to drive better clinical quality and demonstrable patient outcomes.

PRIVACY AND SECURITY IN SUD TREATMENT

While health care providers and vendors are familiar with federal health information security standards and requirements, including HIPAA and HITECH, digital health SUD providers must also comply with federal laws and regulations applicable specifically to substance use disorder treatment records under 42 C.F.R. Part 2 and 42 U.S.C. § 290dd-2 (Part 2), as well as varying state laws and regulations applicable to different telehealth modalities, such as real-time audio-video, interactive audio, or store-and-forward platforms.

Part 2 regulations in particular impose restrictive rules above and beyond HIPAA, including the ways in which SUD treatment records can be disclosed with (and without) patient consent. Federal policies were recently revised with an aim to facilitate care coordination while maintaining strict confidentiality protections against unauthorized disclosure and use.[53]

Maintaining Part 2 compliance requires specialized expertise and processes (e.g., in obtaining a patient's permission to obtain their medical history from another provider or to submit claims to their insurance carrier). These regulations are rapidly evolving, including the above-referenced changes and additional modifications expected in 2021.[54] It is critical that protocols are put in place to protect highly sensitive patient records and contemplate operational challenges to ensure continued, coordinated care.

QUESTIONS FOR POTENTIAL TELEHEALTH PARTNERS

- ☐ What components do you use in delivering services (two-way video, secure text messaging, audio-based, synchronous or asynchronous communications, etc.)?
- ☐ Was your telehealth platform developed internally or does it rely on technology licensed from other vendors?
  - ☐ If built from other vendors and video-based, do you rely on software intended for large, corporate meetings (e.g. Zoom) or is it built with small, secure sessions in mind?
  - ☐ Do you have BAAs in place with all third party vendors?
  - ☐ Is your platform HIPAA- and HITECH-compliant, notwithstanding any temporary federal enforcement waivers?
- ☐ Does your telehealth platform rely on both provider and patient taking actions to make each communication or video session secure, or does your software build security in automatically and remove the possibility of user error?
- ☐ Does your telehealth platform use a single application for all communication, video, messaging, calendaring, meeting reminders, etc., or are you reliant on multiple applications required for the patient interface?
- ☐ Does your platform comply with the modality requirements of our key coverage areas and markets (e.g., video, texting, phone-based, etc.)?
- ☐ How do your information security policies and processes ensure privacy, security and confidentiality of your patients' medical records?
- ☐ How do you monitor up time? What are your business continuity contingency plans?
- ☐ How frequently do you modify your platform to incorporate new features and security updates?
- ☐ How are your operational processes structured to comply with 42 CFR Part 2?
  - ☐ How are you collecting documents requiring patient consent, including release of information (ROI) agreements in compliance with Part 2?
- ☐ What external audits have you completed or are in process of completing?

Addressing Health Equity, Diversity, and Inclusion

Addiction care in the US has long been characterized by racial, class, and geographic inequities in treatment.[55] Telehealth has great promise to reduce systemic health disparities stemming from social determinants, like income, education, and geographic location — particularly by making specialty care accessible and affordable in rural areas.[56] Digital solutions can enable care plans that are customized to meet individual needs.

But we must also acknowledge the potential barriers to telehealth adoption and work to intentionally address them; otherwise, we risk perpetuating health disparities for vulnerable populations.[57]

> "Alongside COVID-19, America has been slowly acknowledging the public health crisis of racial injustice that disproportionately harms communities of color and low-income households, to the detriment of the entire US healthcare system.
>
> Layered on top of our existing, inadequate system, digital health not only doesn't fix the problem: it could exacerbate it. Investment to combat underlying issues will allow telehealth to reach its true potential. Payers and telehealth leaders must develop programs which affirmatively combat structural racism and ensure equitable access."
>
> **— GIL ADDO, CEO & CO-FOUNDER, RUBICONMD**

Communities of color and low-income households are frequently confronted by a digital divide with inadequate access to computers, high-bandwidth internet, and remote monitoring devices. There is underinvestment in technology in community health centers and safety net hospitals which support our Medicaid populations, particularly in rural communities. And people in justice-involved situations, including re-entry from correctional institutions, are at especially high risk of dangerous outcomes.[58]

Telehealth providers should implement dedicated efforts to deliver care with cultural humility and understanding, build a diverse staff with training and education that promotes health equity and anti-racist practices, and promote a culture of social justice.

"Telehealth infrastructure must be built to purposefully close known gaps — in access, equity, and trust — and meet needs for diverse ethnic communities and demographic groups. This includes the people who deliver care, as well as those receiving it."

— REGINA BENJAMIN, MD, CEO BAYOU CLINIC/GULF STATES HEALTH POLICY CENTER, FORMER U.S. SURGEON GENERAL

QUESTIONS FOR POTENTIAL TELEHEALTH PARTNERS

- ☐ What steps have you taken to ensure your program is broadly accessible, inclusive, and meets needs for diverse populations?
- ☐ Do you serve patients who are low-income / Medicaid beneficiaries? What percent of your total panel?
- ☐ Do you serve patients in rural communities? What percent of your total panel?
- ☐ Do you have any programs or tailored support for special populations (e.g., racial, ethnic, language, LGBTQ+)?
- ☐ How do you meet the perinatal and contraceptive needs of patients as this is often a vulnerable group of people?
- ☐ How are you addressing barriers related to digital literacy? What do the demographics of your population imply about who is accessing your program (e.g., age, income level, race, gender identity, zip code, etc.)?
- ☐ How do you support patients with insufficient data/bandwidth or inability to access WiFi to connect to video visits?

Conclusion

Digital SUD treatment holds great potential to bridge access gaps and deliver life-saving care when needed most. In the wake of a pandemic that has accelerated the existing SUD crisis, health plans nationwide are seeking innovative interventions that can improve outcomes and reduce costs. We hope this guide sparks meaningful dialogue with potential partners, and helps you navigate the evolving regulatory, clinical, and technological dimensions of telehealth addiction treatment.

THANK YOU TO OUR CONTRIBUTORS

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